Date of first consultation: ……..…… Doctor: …… Referred by: ……

Please complete the following fields or tick the appropriate boxes. Simply mark unclear questions with a question mark.

Surname:

First Name:

Adress:

Phone:

Profession:

Date of birth: ..... **Age:** .....

Are you married to each other?
O No O Yes (since year) .....

How long have you wanted to have children?
..... (month/year)

How often do you have sexual intercourse with your partner?

- Approx. ..... times a week
- Approx. ..... times a month

Have you already received medical treatment for your infertility?
O No O Yes (since year) .....

- If yes, how many doctors have you already visited?
..... doctors

Previous type of treatment:

Cycle monitoring with intercourse on ovulation
No. of cycles: .....
Pregnancy: O No O Yes

Stimulation of the ovaries with intercourse on ovulation
No. of cycles: .....
Pregnancy: O No O Yes

Insemination
- with sperm from the partner
No. of cycles: .....
Pregnancy: O No O Yes

Insemination
- with donor sperm
No. of cycles: .....
Pregnancy: O No O Yes

Artificial insemination (IVF)
No. of cycles: .....
Pregnancy: O No O Yes

Artificial insemination with microinjection (ICSI)
No. of cycles: .....
Pregnancy: O No O Yes

Thawing cycle (cryotransfer)
No. of cycles: .....
Pregnancy: O No O Yes

OTHER: .....
No. of cycles: .....
Pregnancy: O No O Yes

If you have had previous stimulation of the ovaries or inseminations:
What medication did you receive for this?
.....
.....
.....

Previous IVF or ICSI treatments*:
**If you have already had more than four IVF or ICSI treatments, please state the last four below*

#1
Year..... O IVF O ICSI
No. of oocytes punctured .....
No. of embryos transferred .....
Number frozen .....
Pregnancy O No O Yes

#2
Year..... O IVF O ICSI
No. of oocytes punctured .....
No. of embryos transferred .....
Number frozen .....
Pregnancy O No O Yes

#3
Year..... O IVF O ICSI
No. of oocytes punctured .....
No. of embryos transferred .....

Number frozen .....
Pregnancy O No O Yes

#4
Year..... O IVF O ICSI
No. of oocytes punctured .....
No. of embryos transferred .....
Number frozen .....
Pregnancy O No O Yes

What medication did you receive here?
.....
.....
.....

Have there been complications with IVF / ICSI treatment?
O No O Overstimulation syndrome
O Bleeding O Other (which?)
.....
.....
.....

Have your fallopian tubes already been checked?
O No O Yes (when?) .....

- If so, by which method?
O Ultrasound O X-rays O Laparoscopy

- What was the outcome?
Left fallopian tube: O Patent O Occluded
Right fallopian tube: O Patent O Occluded

Have you already had abdominal or pelvic surgery?
O No O Yes (which?) | Year

.....|.....
.....|.....
.....|.....
.....|.....

When was your last cancer screening?
Year: .....

When was your last mammogram?
Year: .....

Have you already been pregnant?
O No O Yes

- If yes, how long until the pregnancy occurred?
.....

#1
Year.....
O Birth O Misscarriage O Abortion
With current partner? O No O Yes
After fertility treatment? O No O Yes

#2
Year.....
O Birth O Misscarriage O Abortion
With current partner? O No O Yes
After fertility treatment? O No O Yes

#3
Year.....
O Birth O Misscarriage O Abortion
With current partner? O No O Yes
After fertility treatment? O No O Yes

Did complications occur? O No O Yes

At what age did you have your first monthly period?
..... years

Start of breast development?
.....years

Start of armpit and pubic hair?
.....years

How regular were your menstrual cycles in the first years of puberty?

On average every ..... to .....days
O Never had a spontaneous period

Have you used birth control?

Pill: O No O Yes: from..... to .....
IUD/coil: O No O Yes: from..... to .....

Have you been sterilised?
O Yes (when?) .....

Were there any complications?
O Yes (which?)
.....
.....
.....

How long is the interval from the first day of your menstrual period until the first day of the next menstrual period (cycle duration)?

O Regularly between ..... and ..... days
O Irregularly between ..... and .....days
O Currently no menstruation for
O Days ..... O Weeks ..... O Months .....

How long does your menstrual period last on average?
Between ..... and ..... days

How heavy is the menstrual bleeding?
O Light O Moderate O Heavy

Do you have intermenstrual bleeding or spotting?
O No O Yes

Before or after the period?
O Yes, before O Yes, after

Do you have pain during your periods?
O No O Mild O Moderate O Severe

How often?
O Rarely O Occasionally O Always

Do you take painkillers? O No O Yes

When does the pain start?
O before .....
O with ..... the onset of bleeding

When is the pain most severe?
O before .....
O with ..... the onset of bleeding

Have you had pain since your first menstrual period?
O No O Yes

Do you have other lower abdominal pain?
O Rarely O Often O Always

Pain when urinating?
O No O Yes

Pain during a bowel movement?
O No O Yes

Blood in the urine?
O No O Yes

Blood in the stool?
O No O Yes

Pain during intercourse?
O No O Yes

Have you, regardless of pregnancy or breastfeeding, noticed the discharge of secretions from your breast?

O No O Yes O Yes, but only after stimulation

- Since when? .....

- On which side? O On one side O On both sides

- What colour was it?
.....
.....
.....

Do you suffer from the following symptoms?
O No

Acne
Mild O Moderate O Severe O

- Since when? .....

- Where?
Face O Back O Chest O

Increased hair loss?
Mild O Moderate O Severe O

- Since when? .....

Increase in body hair?
Mild O Moderate O Severe O

- Since when? .....

What is your weight and height?
Weight (kilos): ..... Height (cm): .....

Do you have weight fluctuations (> 4 kg)?
O No
O Yes, with increase O Yes, with decrease

Do you do sport?
O Never O Rarely
O Occasionally O Regularly

- If yes, which sports?
.....
.....
.....

Do you drink alcohol?
O Never O Rarely
O Occasionally O Regularly

Do you smoke?
O No O Yes ……. cigs/day

Do you consume other stimulants (drugs/doping agents)?
O No O Yes

- Which?
.....
.....
.....

Do you have any allergies (i.e. medications, antibiotics etc.)?
O No O Yes

- Which?
.....
.....
.....

What medication are you currently taking for any allergies?
.....
.....
.....

Have you had, or do you have any of the following conditions or symptoms?
O No

(since) Year

Diabetes .....
-insulin-dependent O Yes O No

Epilepsy .....

Pelvic pain .....

Asthma / chron. Bronchitis .....

Stomach/intestinal disease .....

Kidney disease .....

Adrenal gland disease .....

Liver disease .....

Heart / cardiovascular disease .....

Cancer / other tumours .....
- Which?
.....
.....
.....

Headache .....

Migraine .....

Has your thyroid already been investigated?
O No O Yes (when?) .....

- If so, by which method?
O Ultrasound O Radiology

- What was the outcome?
O Unknown O Unremarkable

- If abnormal, what were the results?
.....
.....
.....

Are you taking thyroid medication?
O No O Yes (which?)
.....
.....
.....

Have you had any operations other than abdominal or pelvic surgery?
O No O Yes (which?) Year
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....
.....|.....

Do you suffer from any other illnesses and what medication are you taking for them?

O No O Yes (which?)
Medications
.....
.....
.....

Are there any hereditary diseases in your family, cancer, other serious illnesses or infertility?
O No
O Yes, on my mother's side (who?)
.....
.....
.....

O Yes, on my father's side (who?)
.....
.....
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Comments:

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